

**Challenges to concordance:
theories that explain variations in patient response.**

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Abstract

The meet the challenges of an increasingly ageing and multimorbid population, there is an urgent need to fully engage the patient to work in partnership with their health care professional in the management of their condition(s). Without this consistent approach to partnership working with the patient, there is a real concern that the National Health Service (NHS) will not be able to cope with demand.

The NHS Long Term Plan (2019) outlines a range of envisioned goals to manage these increasing demands, including hospital admission avoidance, shorter length of hospital stays through enhanced recovery pathways, increased management of patients within primary care and the need to ensure a person-centred approach to care provision. The Plan (NHS, 2019) suggests that these goals will, at least in part, be achieved by patient empowerment, informed shared decision-making, and enhanced self-management. This is predicated on health care professionals (HCP) being equipped to empower patients using the skills of motivational interviewing, a person-centred focus care delivery and a willingness to share decision making. Alongside HCP requirements, there needs to be a willingness on the part of the patient to engage in shared decision making and self-management is also necessary.

With the impact of effective patient engagement being significant and concordance being the goal, why do some patients engage with advice and agreed treatment plans whereas others seem to do everything possible, or so it appears, to follow a different plan? This article presents a range of psychological theories that go some way to explaining the day to day challenges that are faced in the delivery of care. Awareness of these theories may provide an insight that enables health care professionals to target their approach to care delivery more effectively, to understand patient responses and, therefore, optimise the provision of person-centred care.

Key words: concordance; person-centred care; psychological theories; decision-making; self-management.

Challenges to concordance: Theories that explain variations in patient responses.

Background

Over the last 30 years, we have become increasingly aware of the challenges posed by an ageing population who present with multiple conditions (Kingston et al, 2018). The provision of clinical care in the United Kingdom (UK), most often delivered by the National Health Service (NHS), is a finite resource. The overwhelming effect of the demographic changes we are experiencing in the UK directly impacts capacity within the NHS; a situation that is being mirrored worldwide (Vetrano et al, 2017). We often notice these pressures most when faced with the frequent national newspaper headlines, including ‘bed-blocking’, trolley wait breaches in Accident and Emergency (A&E) departments, emergency service call-out and attendance delays, a lack of social care capacity, National Institute for Health and Care Excellence (NICE) restrictions to drug funding and cancelled operations (Iacobucci, 2017). It appears that there are infinite demands on our finite service.

Alongside these substantial demographic changes, we are concurrently challenged by considerable staff shortages across NHS provision, which are predicted to rise to in excess of 250,000 by 2030 (King’s Fund, 2018). These shortages impact on the full range of clinical roles with an estimated 40,000 nurse vacancies (RCN, 2017) and a reported fall in General Practitioner (GP) numbers by 450 full time equivalents (FTE) between September 2017-2018 (Iacobucci, 2019). The ambition to enhance care provision is also further challenged by the ongoing impact of economic recession which has led to considerable and wide-ranging austerity measures (Stuckler et al, 2017). Healthcare expenditure is often the first to experience funding cuts which impacts on core services but, in addition, there has been a stark reduction in community support services (Age UK, 2018). Indeed, Mencap (2016) report a 33% decrease in community-based support services for the elderly and those with learning disabilities. These factors further challenge the effectiveness of plans to promote and support patient empowerment and

self-management.

The NHS Long Term Plan (LTP) (2019), published in January of this year, aims to direct care provision over the next 10 years and firmly focuses on a need to ensure that our patients remain within primary care; keeping the patient at home with hospital admission avoidance and shortening lengths of stays as much as possible, is central to coping with unprecedented demand. Indeed, the LTP (NHS, 2019) sets out a plan of action, supported by new money, delivered across a number of Primary Care Networks (PCNs). The PCNs will comprise multidisciplinary teams (MDT), equipped to empower patients to concord with mutually agreed, ambitious plans of care, aimed at maintaining health for as long as possible.

For such plans to be effective, partnership working between health care professionals (HCP) and their patients is fundamental. Clear information, shared decision-making, effective care planning and realistic goals for self-management will need to be at the core of care provision across the NHS (NHS, 2019). For such plans to be effective, a concordant relationship between patient and HCP is essential; such relationships will be underpinned by trust and negotiation, indeed, a relationship of equals with shared goals rather than a paternalistic approach (Morley & Floridi, 2019). Theories of person centredness were espoused by Ballint as long ago as 1957 but are still not consistently in place (Ballint, 1957; Bhattacharyya et al, 2019).

Concordance is based on the sharing of information and the development of negotiated and agreed goals; in contrast to compliance, which requires adherence to a dictated plan with little or no negotiation. By its nature, compliance is often short-lived, with patients quickly demonstrating non-adherence to the plan set (Bissell, 2004). In order to achieve the goals of a concordant relationship, the LTP (NHS, 2019) elaborates that this will be underpinned by the implementation of seamless technology to support information sharing and to fully equip patients to engage with informed and shared decision making with their HCP.

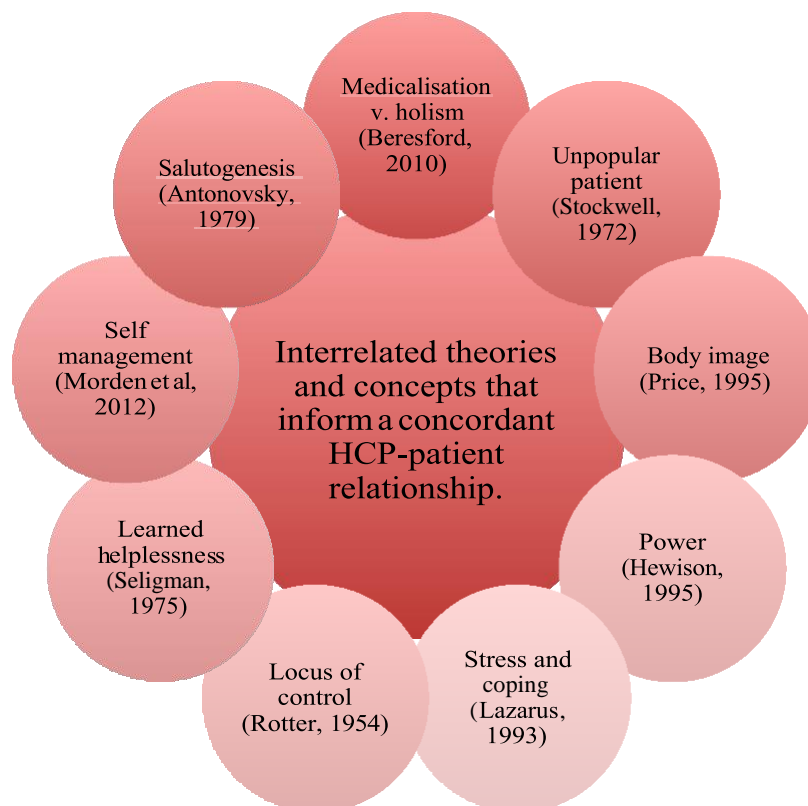
Challenges to concordance.

On occasions, despite our best efforts as HCPs to share information and develop a relationship of 'equals' with our patients, some patients still fail to concord (Hewison, 1995; Seligman, 1975; Morden et al, 2012; Felzmann, 2018). Apparent non-concordance

may occur despite our best efforts to engage the patient in self-management and to share decision-making. Such situations often leave HCPs considering why this is the case.

There are a range of theories, some of which are quite dated, that go some way to explaining this conundrum and may well inform more effective approaches to engaging certain patients as partners in care. These theories, as a minimum, serve to enhance our understanding of the HCP-patient relationship but, at times, may go some way to explain the actions and reactions of each party within this complex relationship. Indeed, these theories may help to explain situations where concordance poses a challenge. Each of the theories are presented within this article alongside suggestions for potential alternate approaches to care delivery (Figure 1).

Figure 1: Interrelated theories and concepts that explain patient actions and reactions.



Medicalisation and holism.

The term medicalisation describes a ‘reductionist’ philosophy, most often linked with a medical approach to care delivery, which is underpinned by an aim to describe and define the disease process (Ahn et al, 2006; Beresford, 2010; Gray, White & Russell, 2015). Indeed, the aim of medicalisation is to develop an understanding of the management of

the disease process. However, medicalisation is often criticised for focusing on the minutiae of disease and often its prevention but lacking an insight into the ‘bigger’ picture, which includes the impact of the condition on the patient (Ahn et al, 2006). Gray, White & Russell (2015) acknowledge a range of new pressures to ‘medicalise’ including that driven by the patient as an ‘expert patients’, Government programmes such as the Quality and Outcomes Framework, the ‘industry’ of lifestyle medication and the lowering of treatment thresholds and routine screening. Gray, White & Russell (2015) purports that “medicalisation means medication for millions” (Gray, White & Russell, 2015; p. 7), with lowered thresholds for a range of diseases.

The risk of a medicalised approach is that the condition or ‘disease’ is disassociated from the patient and their experiences (Beresford, 2010). A problem, it is said, that is intensified with an increasing reliance on evidence-based medicine (EBM), rather than the effectiveness of treatment and management within a real-life context (Beresford, 2010). Beresford (2010) warns that advice from HCPs who adopt a medicalised approach may be so specific, that any application to a real patient may lead to harm or, as a minimum, might disengage the patient. This effectively sums up the traditional medical model, where dialogue may be paternalistic and imposed rather than negotiated. In such a situation, patients do not perceive themselves as equal partners in a relationship and often feel disengaged with their plan of care. An example of such a situation would be the implementation of an aggressive and challenging management plan for a patient with an advanced diagnosis of cancer without negotiating the patient’s care priorities for their future care. Such a lack of involvement in planning may simply result in a disengaged patient who does not feel that their voice is heard or valued.

In contrast to the medicalised model, holism represents an opposite approach, emphasising the centrality of the patient within the disease process and the need for the whole person to be accounted for within the delivery of care. In order to optimise concordance, it is suggested that holism should be the goal of patient-centred care delivery and is effectively summed up by Beresford (2010) as

“.... looking at the patient and disease as a whole rather than focusing on interactions at cellular level.” (Beresford, 2010; p. 721)

Historically, the first truly holistic practitioner in nursing was Florence Nightingale. Florence Nightingale emphasised a need to focus care on the whole patient, with an

awareness of the influence of environmental factors on health and recovery (Dossey, 2010).

Contemporary issues within healthcare systems questions whether our current approach to care delivery and nursing are truly holistic, especially since care is most often delivered within specialist silos, with an emphasis on a single disease focus, despite the growing prevalence of multimorbidity (Smith et al, 2011). The themes stressed within holism include the centrality of the patient as a whole, positioned at the centre of the care dialogue and are at the heart of person-centred care. Such themes, however, are not without their challenge within an in-patient setting, as patients are quickly discharged, fast tracked or transferred. This minimises the opportunity for meaningful dialogue, goal setting and an effective holistic approach to care delivery.

The unpopular patient.

In 1972, Stockwell published her seminal text entitled ‘The Unpopular Patient’. This publication explored interpersonal relationships between the nurse and their patient and was undertaken within hospital wards. The focus of Stockwell’s (1972) study was the interaction between the patient’s and the nurse’s personality; Stockwell (1972) aimed to investigate the meaning behind why some patients were classified as “difficult’ by their nursing staff. Stockwell (1972) described these ‘unpopular’ patients as

“...patients whom the nursing team enjoys caring for less than others.” (Stockwell, 1972; p. 11)

The impact, Stockwell (1972) found, of this classification on patient care was surprising, with results identifying a middle group of patients who were categorised as being neither popular nor unpopular, but who were subsequently deprived of attention (Stockwell, 1972). Stockwell’s (1972) research, at the time, was extremely contentious and challenged the widely held view that nurses were non-judgmental in their care. This research, although now dated, remains relevant and, when most nurses consider the care that they deliver, will be able to identify those to whom care is more easily delivered.

More recently, the description of patients as ‘heartsink’ was coined within general practice (O’Dowd, 1988) and mirrors Stockwell’s (1972) ‘unpopular patient’. ‘Heartsink’ was used to refer to patients who caused their HCP, generally the GP in O’Dowd’s (1988)

study, to feel ‘heartsink’ when they consulted with them (Moscrop, 2010). Ellis (1986) had previously described such patients and a feeling as ‘dysphoria’, which he described as:

“the feelings felt in the pit of your stomach when their (the patients’) names are seen on the morning’s appointment list”. (Ellis, 1986; p. 318)

O’Dowd (1988) described such patients as being thought of as dissatisfied, manipulative, demanding and frequent complainers but, on closer inspection, O’Dowd (1988) found that they actually represented a disparate group of complex patients. The views expressed by O’Dowd were amended during ensuing years (Moscrop, 2010).

The ‘heartsink’ description displayed many similarities to Stockwell’s (1972) ‘unpopular patients’ and the revelations about nurse attitudes. ‘Heartsink’ patients, studies demonstrate, may experience ineffectual management of their condition as a result of the ‘heartsink’ impact on the HCP concerned, who may be frustrated and act in an unprofessional manner during clinical contact (O’Dowd, 1988; Moscrop, 2010).

These studies suggest that patients may fall into the category of being unpopular, difficult or ‘heartsink’, without actually being aware of such marginalisation or the impact that such a ‘label’ may have on their subsequent care (Stockwell, 1972; O’Dowd, 1988). Although the original studies are now dated, more recent studies have identified similarities (Bass, 2016). Such evidence suggests that HCPs need to be aware of any prejudices that they hold, in order to ensure that all in our care are provided with the same level of care.

Body image.

Everyone has a personal perception of their body; this is the picture of our body that is held in our mind and ultimately defines how we see ourselves (Schilder, 1935). Changes to our physical appearance, which may be as a result of illness or disease, have an impact on our personal identity and may displace our view of ourselves (Price, 1999; 2000). Price (1999) worked extensively in the area of body image and claimed that the initial steps to correct a distorted body image, early in an illness trajectory, may be successful but, often, as the course of the illness or disease progresses, the effectiveness of such interventions diminishes and, as a result, the illness actually stigmatises the person due

to their changed appearance and general loss of bodily control (McIntyre, 1995; Price, 1999).

Price (1995) describes altered body image as,

“a state of personal distress, defined by the patient, which indicates that the body no longer supports self-esteem, and which is dysfunctional to individuals, limiting their social engagement with others.” (Price, 1995; page 180)

Altered body image is extremely common in, although not limited to, palliative cancer care, and may result from a person’s diminished ability to manage the impact of their illness or as a result of the reactions of others to their condition (Cook, 1999); indeed, it is generally associated with a perception of a loss of control by the patient (Price, 1998).

Such changes to body image also impact on a range of patients including but not limited to those who have required surgery, those with wounds requiring visible dressings, etc. Patients requiring lower limb dressings are a group where concordance to treatment may be impacted by the appearance of dressings (Williams, 2010); a negotiated approach to ensure concordance will result in the best response from the patient. It is important that the HCP reassures the patient and aims to minimise the impact of their condition on the patient’s perception of their body image, as this can impact on concordance with treatment regimes.

Power in the health care professional-patient relationship.

The HCP-patient relationship is not necessarily one of equals (Beck, 1997; Henderson, 2003; Barry & Edgman-Levitan, 2012) and this is a factor that impacts on the effectiveness of any ensuing dialogue.

Power in the nurse-patient relationship was explored using by Hewison (1995); he analysed and explored the language used during nurse-patient interactions, concluding that nurses used language to exert power over their patients; a behaviour that was generally accepted as normal. Despite the accepted ‘normality’ of this, such behaviour presented a barrier to the development of a collaborative nurse-patient relationship and often prevented open and meaningful communication. Hewison’s (1995) study

confirmed that the majority of nurse-patient interactions were trivial, routine and related to tasks. This assumption was corroborated by studies by Henderson (2003) and McCabe (2004) who also found that the impact of power in HCP-patient dialogue served to limit disclosure and thus impacted on the agreement of appropriate interventions.

Corless, Buckley & Mee (2016) more recently explored the imbalance of power between the patient and HCP and evidenced the negative impact of such dialogues on the patients' experience of care. The nurse's interactions are often workload driven rather than being intentionally aimed at distorting the quality of care delivered, however, whatever the underpinning reasons, the impact on the patient's experiences of care are negative as a result. HCPs need to be conscious of their interactions with their patients to ensure that a power relationship is avoided. Corless, Buckley & Mee (2016) state that:

“Nurses may possess a number of attributes that place them in a powerful position in comparison with their patients. These include professional status, professional knowledge, being free of pain and fear, and being in a standing position rather than lying in bed.” (p. 20)

Stress and coping.

Theories of stress, coping and health are often derived from Lazarus' (1993) original Transactional Model; this was developed in response to an increasing interest in the area of stress in the 1960s and 1970s. Responses to stress, Lazarus (1993) believed, depended on the meaning that an individual attributed to the stressful stimulus, thus having an effect on both health behaviour and coping. Lazarus (1993) proposed that coping efforts were dependent on primary and secondary appraisals of an impending stressor.

Primary appraisal, Lazarus (1993) explained, referred to an assessment of the threat that a situation poses to an individual. Secondary appraisal referred an individual's assessment of the resources available to them to cope with the stressor. These responses, Lazarus (1993) believed, could be a problem-focused strategy, such as information seeking, or an emotionally-focused strategy, such as changing personal thinking about a situation, avoidance and denial.

The application of Lazarus' (1993) Transactional Model supports the positive benefits of social support for an individual in respect of both well-being and health. Indeed, social support is important, although Schwarzer and Leppin (1991) suggest a more complex interaction with social support mediating the effects of illness and also directly effecting illness. The Transactional Model (Lazarus, 1993) underpins the need for support mechanisms for patients, to empower them to cope with the challenges that their condition and treatment presents. This model also goes some way to explain a person's responses to multiple stressors, whereby secondary appraisal may, in fact, reinforce a belief that a person can no longer cope and that they have no more strategies to cope with the stressors presented.

Models that identify the benefit of social support, against a backdrop of diminishing resources (Gerst-Emerson & Jayawardhana, 2015), present many challenges to HCPs. Indeed, austerity has impacted many of the resources previously been utilised to support the more isolated patients and, with loneliness impacting on the health of many patients, not least the elderly (Age UK, 2018), referral pathways are more limited, and solutions are harder to achieve.

Locus of control.

Many studies have aimed to explore personal characteristics in order to establish why patients act and react in a certain way; one such psychological theory is known as locus of control and was expounded by Rotter in 1954. Rotter (1954) aimed to describe the degree that a person believes that they can control the events that impact on their life.

A person's locus, or place, is described as being either 'internal' or 'external'. Rotter (1954) explained that when a person's locus of control was internal, they held a belief that they are in control of their life. In contrast, those whose locus of control was external, felt that they and their decisions were controlled by factors that were beyond their control (Rotter, 1954).

The theory of locus of control has the potential to have a significant impact on a person's ability to engage in self-care and whether they feel that they are able to make effective changes in order to improve their health outcomes. Indeed, those with an internal locus

of control tend to cope well with their diagnosis and are often keen to engage with self-management, believing that this will improve their outcomes. In contrast, those with an external locus of control prefer their condition to be ‘managed’ by their HCP, with a reluctance to engage in self-management. Indeed, a study by Musich, Wang, Slindee, et al. (2019) demonstrated the impact of an internal locus of control in their study about the experiences of pain in older adults. Their analysis evidenced that those with an internal locus of control had lower pain severity, reduced chronic opioid use and increased physical functionality.

An awareness of a patient’s locus of control may enable HCP to negotiate plans of care and provide the level of support required, which may differ substantially between patients. Enhanced psychological and emotional support may well be required for those whose locus is external.

Learned helplessness.

Another personal characteristic that is relevant to person centred care and the effectiveness of consultations is ‘learned helplessness’. This trait was identified by Seligman (1975) and was used to describe why some people, when faced with a negative situation, have a tendency to behave helplessly and remain passive, despite, potentially, having an opportunity to correct the situation.

Seligman (1975) conducted experiments on both dogs and humans and adopted the phrase ‘learned helplessness’ to describe a belief that events were out of an individual’s control. In addition to the negative expectations held by those with learned helplessness, Seligman (1975) identified that such feelings were often accompanied by feelings of low self-esteem and persistent failure.

Smallheer (2017) further explored the impact of learned helplessness on depressive symptoms following myocardial infarction. Smallheer (2017) demonstrated a statistically significant relationship between learned helplessness and depressive symptoms, suggesting higher self-reported levels of learned helplessness were linked to the report of increased depressive symptoms.

Learned helplessness results when a person is repeatedly unsuccessful in dealing with “unfavourable situations” that are stressful or challenging. This impacts on motivation, cognition, and a person’s emotions; minimising the expectation that things will improve as a result of personal action and, thus reducing future attempts to react to an unfavourable situation (Seligman, 1975; Smallheer, 2017). Understanding patients who exhibit learned helplessness is vital in order that HCPs can focus their consulting approach to effectively engage, encourage and motivate them. Goal setting, motivational interviewing and effective person-centred approaches may serve to minimise learned helplessness.

Self-management theories.

The theory of self-management is embedded in current policy and practice (DH, 1991; 2001a; NHS, 2019; NHS, 2019) and is defined as care directed and led by the patient (Morden et al, 2012). The term self-management is the key to a patient centred health care system and fundamental in the effective management of long-term conditions (LTC) (DH, 2005; NHS, 2019). The theory of self-management is underpinned by a patient’s motivation to engage in their care and is linked to the previously described theories of locus of control (Rotter, 1954) and learned helplessness (Seligman, 1975).

The elements that underpin the adoption of self-management are encapsulated in the theory of self-determination; a theory initially described by Deci and Ryan (2000). Self-determination focuses on two types of motivation for health: controlled and autonomous. People who demonstrate a ‘controlled motivation’ have a tendency to undertake interventions for extrinsic reasons, for example for a specific reward or to make people happy. In contrast, those with ‘autonomous motivation’, act for intrinsic reasons, undertaking things for the benefit of themselves. Autonomous motivation has similarities to internal locus of control (Rotter, 1954) and can be seen as a predictor of positive changes for health benefit and key to self-management and a range of positive health interventions (Deci & Ryan, 2000).

Alongside self-determination are social learning theory or self-efficacy (Bandura, 1977); this theory is also implicated in a patient’s positive motivation to engage in self-management and focuses on an individual perceiving that they are able to undertake the behaviours necessary to improve their health; again, behaviours predictive of self-

management (Bandura, 1977; Skinner et al, 2003). Indeed, a personal belief in one's own ability to improve health outcomes is often predictive of the success of treatment interventions and impacts on their compliance with such regimes (Deci & Ryan, 2000). In opposition, controlled motivation, as with an external locus of control, may see patients disengaging, preferring their HCP to 'manage' their condition for them.

An understanding of these underpinning theories is important as it may influence the approaches adopted by HCPs. Self-determination underpinned by autonomous motivation and self-efficacy are predictive of a self-motivated patient, keen to optimise their health outcomes, engage in self-management, underpinned by a belief that improved outcomes are achievable. However, those with controlled motivation and an external locus of control may need a different plan of care, that is more directive, alongside motivational interviewing to inspire some degree of concordance to plans to improve outcomes.

Salutogenesis.

Antonovsky (1979; 1987) contested the widely held biomedical model of health and proposed a new 'continuum model' of health model. The model describes that each person is positioned, at any point in time, on a health/disease continuum (with health termed salutogenesis and disease termed, pathogenesis).

Antonovsky (1987) stressed the importance of the person's 'sense of coherence', a unique attribute held by each of us. Antonovsky (1987) described the sense of coherence as an individual's approach to the world which perceives it as "comprehensible, manageable and meaningful" (Johnson, 2004; page 420). The sense of coherence, Antonovsky (1987) felt, was significant in an individual's movement toward the health end of the continuum when faced with a particular stressor. Those with a strong sense of coherence would understand the challenge, be motivated to cope and would apply the resources required (Antonovsky, 1987). Again, similarities can be seen with an internal locus of control and self-efficacy (Rotter, 1954; Bandura, 1977).

Antonovsky (1979) also expounded the importance of something he termed 'generalised resistance resources' (GRRs). He described these as the properties necessary to enable a

person to cope, to view the world as making sense, cognitively, instrumentally and emotionally. GRRs were described as biological, material and psychological factors which make it easier for people to see their lives as consistent, structured and understandable. GRRs include money, knowledge, experience, self-esteem, being loved, healthy behaviour, commitment, social support, cultural capital, intelligence, traditions and view of life (Antonovsky, 1979). Antonovsky (1979) felt that sufficient and appropriate GRRs facilitated movement towards the health end of the continuum. Antonovsky (1979; 1987) proposed that if a person has some or all of these GRRs at their disposal, they would have a better chance of coping with the challenges of life (Antonovsky, 1979; 1987; Lindstrom & Eriksson, 2005; 2006).

Research demonstrates that in all age groups, socioeconomic backgrounds and cultures, those who demonstrate a strong sense of coherence, experience better perceived health, improved mental well-being, healthier ageing, enhanced quality of life (Antonovsky, 1987; Lindstrom & Eriksson, 2006). Conversely, those with a weak sense of coherence experience poorer perceived health and often low mood (Antonovsky, 1987; Lindstrom & Eriksson, 2006). Clear links can also be seen with locus of control (Rotter, 1954), learned helplessness (Seligman, 1975) and self-management theories (Morden et al, 2012). Salutogenesis has obvious implications for the adoption of self-management strategies and the development of a concordant relationship. It can be clearly seen that patients who lack a sense of coherence and GRRs, are often those who are unable to motivate themselves to self-care, as they have limited personal resources at their disposal.

Discussion.

The psychological theories presented; all have the potential to impact the ability of our patients to self-manage their health conditions. Indeed, the success of the LTP (NHS, 2019) and the ability of the NHS in the 21st century to cope with unprecedented demands is predicated on a high proportion of patients engaging in self-management, supported by their HCP. As can be seen in the theories described, many issues and factors can impact a person's belief that self-care can be effective; this may be based on previous failures, negative feedback, poor understanding of what is required or a lack of GRRs (Antonovsky, 1987).

Those patients with an internal locus of control (Rotter, 1954), a strong sense of coherence (Antonovsky, 1987), who demonstrate self-efficacy (Bandura, 1977), a problem focused strategy (Lazarus, 1993) and autonomous motivation (Deci and Ryan, 2000) are, most probably, our patients who are easy to motivate to self-manage. They are enthusiastic, engaged and perceive that their outcomes will improve. Such patients adhere to advice, engage with shared care, investigate their condition, etc.

In contrast, those patients who have an external locus of control (Rotter, 1954), who lack a sense of coherence (Antonovsky, 1987), who demonstrate an emotionally focused strategy (Lazarus, 1993) and controlled motivation (Deci and Ryan, 2000) will question their ability to engage and whether they can truly make a difference to their health outcomes.

These psychological theories, however, are not necessarily permanent. For the patient who, in the past, has tried and failed to manage their condition(s), they may feel demoralised and less likely to engage in the future. Encouragement and motivation from HCPs can, over time, re-motivate patients, invigorating them to re-engage with their condition, participate with their shared care plan and achieve incrementally stepped negotiated goals.

With enhanced self-management our goal, ‘patient activation’ is a term that describes ‘the extent to which individuals are able to manage their own healthcare’ (Magnezi et al, 2014). Hibbard et al (2004) designed a simple model entitled the Patient Activation Measure (PAM) to assess a person’s confidence in engaging with self-management. Results range from not believing they have any role in self-care to being actively engaged in self-management health behaviours. A number of studies have evidenced that an initial focus on enhancing a person’s self-assessed ‘activation’ level, may result in improved responses to self-management interventions over time (Deen et al, 2011; Shiveley et al, 2013).

Challenges that may impact on the effectiveness of practitioners to promote self-management include significant demographic challenges, the workforce crisis and the impact of austerity but also the preparedness of practitioners to handover the ‘control’ of

long-term condition management to their patient and the challenges that this might bring. Healthcare is an equal partnership and there is a need to acknowledge that we, as clinicians do not hold all of the answers. We are often confronted by a 'google' population of patients; indeed, health information is one of the most frequently searched topics on the internet (McMullan, 2006) and health-related websites have a considerable influence on the behaviour of website 'users' (Turan et al, 2015). Patients often consult with their HCP already armed with a level of web-based 'information', albeit often of dubious quality or relevance, but this in itself is patient engagement and should not be discouraged. It is our role, as HCPs, to guide patients to appropriate evidence-based websites and to not feel threatened by such information-seeking behaviours as these may be classified using PAM (Hibbard et al, 2004) as active engagement with self-management behaviours.

Conclusion.

The range of psychological theories presented have the potential to enhance or diminish person centred care, communication between the HCP and the patient during their consultation and the patient's ability to engage concordantly with self-management. Each 'theory', however, poses potential challenges which may lead to mismatched goals and an impact on the patient's expectations of improved self-management. The HCP is often the key to providing appropriate motivational goals for their patients.

It is the role of the HCP to recognise these underpinning theories within their patient population and to vary their approach accordingly, in order to optimise outcomes. Theories are theories and, adopting the right approach for the patient, can impact on their self-belief, and potentially permit patients to see that changing their mind-set might make a difference to their outcomes. Motivational interviewing, an awareness of the patient's activation level, a stepped approach to shared care, providing staggered, clear information over time, celebrating small successes and planning a gradual handover of health objectives, may well motivate those who lack the outward signs that they are prepared to fully engage in shared care.

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4 key points:

1. The LTP (2019) will only be effectively operationalised if we engage patients to become involved in their care.
2. Patient activation is a key element of self-management.
3. Realistic goal setting will encourage patients to perceive their engagement as manageable and effective.
4. Patient engagement with self-management may vary over time Don't give up!

3 reflective questions:

1. If you were a patient yourself, which psychological theories would summarise your response to your health care needs?
2. Think of a 'challenging' patient scenario that you have experienced. Which of the psychological theories may have gone some way to explain your patient's responses?
3. How would you activate and empower patients more effectively in the light of what you have read in this article?